DEMOGRAPHIC INFORMATION FORM TO BE COMPLETED BT PATIENT (18 years & older or UIP)

Date of Visit _____ **DOB** _____ **Sex at Birth - Male** ☐ **Female** ☐ **Social Security #** (optional)_____

Legal Last Name _____ **Legal 1st Name** _____ **MI** ____

Preferred Name/ Pronoun _____/_____ **Race** (e.g., Asian/ Black/ White) _____ **Hispanic - Yes** ☐ **No** ☐

Home # _____ **Cell/ #** _____ **Email Address** _____

Emergency Contact Name _____ **Relationship** _____ **Phone #** _____

May we contact you via email? Yes ☐ **No** ☐ **Would you like a text message for appointment reminders? Yes** ☐ **No** ☐

Would you like to complete an Advanced Directive today? Yes ☐ **No** ☐

An advanced directive (living will) allows someone to make medical decisions on your behalf if you are unable to.

Would you like to participate in the Health Information Exchange (HIE)? Yes ☐ **No** ☐

The HIE allows your medical information to be available and viewed electronically by doctors and your medical team members. It is designed to provide quick access to medical records to make treatment more effective and efficient. Any authorized healthcare provider and their team who agrees to participate in the HIE can electronically access and use your protected health information, if needed, to provide treatment to you.

Please list all family members living in your home and note monthly income if applicable

(Income includes all earnings from jobs, pensions, child support, social security, death benefit, alimony, unemployment/worker's compensation, veteran benefits, investments, trust funds, rental income, self-employment, Public Assistance, grants or any other income received.)

Name	Date of Birth	SS# (optional)	Relationship	Monthly Income

I affirm the information I am providing is true and correct to the best of my knowledge. I understand if I provide false or inaccurate information services may be discontinued and I may have to pay for all services received per the appropriate fee schedule. FACS64f10.003 (5).

Signature _____ **Date** _____

DEMOGRAPHIC INFORMATION FORM TO BE COMPLETED BT PATIENT (17 years & under)

Date of Visit _____ **DOB** _____ **Sex at Birth - Male** ☐ **Female** ☐ **Social Security #** (optional)_____

Legal Last Name _____ **Legal 1st Name** _____ **MI** ____

Preferred Name/ Pronoun _____/_____ **Race** (e.g., Asian/ Black/ White) _____ **Hispanic - Yes** ☐ **No** ☐

Home # _____ **Cell/ #** _____ **Email Address** _____

Mother 1st, Last Name & DOB _____/_____ **Father 1st, Last Name & DOB** _____/_____

Your Name _____ **Relationship to child** _____ **Legal Guardian Yes** ☐ **No** ☐

Emergency Contact Name _____ **Relationship** _____ **Phone #** _____

May we contact you via email? Yes ☐ **No** ☐ **Would you like a text message for appointment reminders? Yes** ☐ **No** ☐

Would you like to complete an Advanced Directive today? Yes ☐ **No** ☐

An advanced directive (living will) allows someone to make medical decisions on your behalf if you are unable to.

Would you like to participate in the Health Information Exchange (HIE)? Yes ☐ **No** ☐

The HIE allows your medical information to be available and viewed electronically by doctors and your medical team members. It is designed to provide quick access to medical records to make treatment more effective and efficient. Any authorized healthcare provider and their team who agrees to participate in the HIE can electronically access and use your protected health information, if needed, to provide treatment to you.

Please list all family members living in your home and note monthly income if applicable

(Income includes all earnings from jobs, pensions, child support, social security, death benefit, alimony, unemployment/worker's compensation, veteran benefits, investments, trust funds, rental income, self-employment, Public Assistance, grants or any other income received.)

Name	Date of Birth	SS# (optional)	Relationship	Monthly Income

I affirm the information I am providing is true and correct to the best of my knowledge. I understand if I provide false or inaccurate information services may be discontinued and I may have to pay for all services received per the appropriate fee schedule. FACS64f10.003 (5).

Signature _____ **Date** _____